BULLETIN

OF THE

SOUTH INDIAN MEDICAL ASSOCIATION.

MARCH 1934.

FELICITATIONS.

Our felicitations to Dr. T. Satakopan, M. D., who, we understand, has been invited to join the Board of Studies of the Madras University. As things stand now, it is fairly hard for any member of the Independent Medical Profession to enter the sacred portals of the University Councils. We are not wrong in saying that the inclusion of the Honorary Members of the teaching staff of the local hospitals to the academic strength was viewed with disfavour by the high priests of the provincial service and but for the broad-mindedness of the then higher authorities even the few that are now included in the teaching strength would not have been there. We feel sure that Dr. Satakopan is an acquisition to that body and will be able to give valuable counsel in problems affecting the medical profession as a whole and specially in those concerning the essentials required to turn out a reliable general medical practitioner.

The Medical Budget.

There is nothing very striking in the provision made for the expenditure on medical relief and education in the Budget estimates for the ensuing official year. There is a small increase of 4·5 lakhs of rupees over the amount actually spent in the year that is closing. But this small increase is chiefly taken up by the increments in the pay of establishment. There is no provision for any increase in the number of hospitals and dispensaries, nor any for the increase of accommodation in these crowded institutions. It would perhaps be unreasonable to expect such progress during times of financial difficulties. But one would have expected at least some provision for starting new centres of relief in the rural areas. It is therefore disappointing that the provision for subsidized rural dispensaries has been left where it was in the previous year.

Creation of new appointments and additions to the cadre of civil surgeons have been a feature of the medical department in the recent past. The fact that some of these posts are being abolished and certain others are being manned by officers of a lower cadre bear eloquent testimony to the haphazard manner in which schemes were evolved and the hurry with which officers were promoted from one cadre to another, In spite of the need for the careful husbanding of the available resources, we are afraid that retrenchment and new appointments still go hand in hand. We admit that new appointments have not the merry swing that was in evidence a few years ago. But they are still created, and with no better reasons than before. In the Budget under consideration we find that some provision is made for additional staff for the teaching of Medical Jurisprudence in the Madras Medical College. At the time that a full-time professor for this chair was appointed, it was argued that the creation of this new full-time chair was economical since a number of appointments related to the subject would be abolished. But within a few months of the working of the scheme, there is already a demand for additional staff. Again it is mentioned that provision is made for additional medical staff for the new surgical block that is to be shortly opened in the Government General Hospital. This is rather curious. For, we understand that when the desirability of appointing honorary staff to the surgical department was pointed out, it was said that there was no room for additional staff. We are pleased however that the authorities have so soon realized the need for more staff. But it is difficult to see why this new staff could not be all honorary.

We find that there is a large number of civil assistant surgeons who are shown as reserve. We do not know if this is the normal number. But it strikes us that the number is excessive. We know also that a few months ago many assistant surgeons were walking the wards of the various hospitals in the city as officers on reserve duty. The government is evidently in a quandary. They have evidently more officers on hand than they could usefully employ. The officers get their pay, and the Government is probably saved some awkward questions. But one would like to know whether the rate-paying citizen is fully satisfied with this arrangement for spending his contribution.

It is not profitable to go into the details of the budget. But as one goes through this document and its predecessors, one cannot escape the feeling that there is no reasonable policy behind the administration of medical relief and education. A system that worked well, very well indeed, about twenty years ago, is still kept going with additions and alterations as determined by day-to-day

needs. It is a mosaic which does not please the eye since accident has forced incongruous and incompitable bits to lie side by side. The system needs looking into. And we consider that this is the best time. For, with the present finances, expansion is not possible. We can certainly make what we have more pleasant and serviceable.

Honorary-Baiting.

The controversy initiated by the Rotarians in Calcutta regarding staffing of the hospitals and the reply to it by Col. Proctor, the acting Surgeon-General there, has found its repercussion in this Presidency. Successive Surgeon-Generals have viewed sympathetically the aspirations of the Independent Medical Profession. They have realised that the problem of medical relief in the Presidency could only be adequately met by improving the standard of the whole medical profession and not by pampering to the clamourings of a section. The initiation of the honorary scheme, the development of indigenous talent, the expansion of the system of subsidized rural practitioners have all been expressions of that view. We do know that some members of the Services have been opposed to them and have vehemently protested and where possible created friction in the successful working of the honorary system. It is fortunate that only a few have been imbued with that view and that this was not allowed any free play during the previous regimes. Coming as he does from Calcutta, Sir Frank Connor's arrival was hailed with glee by that section of the Service which stood against the expansion of the honorary system. They hoped and still hope that he will put the kybosh on the honorary. We are constrained to mention this as very recently the honorary-baiting has re-started with fresh impetus. We have been recently receiving letters from various places about the difficulties that they have to content with and the inconveniences they are put to now. The repressed animosity is now being given free vent. We have no fears anyhow. We feel sure that the destinies of the honoraries are in quite safe hands and that the present Surgeon General is as much interested in the expansion of medical relief and the growth of a healthy and strong independent medical profession as his predecessors were.

Unity.

Doctors and Watches have one thing in common. No two, of these agree. This was well exemplified in the recent elections for the Indian Medical Council where two members of the Independent Medical Profession, and those, responsible officers of the Union, contested the seat. We had felt that this was because the independent profession was not organised enough, and with better organisation such things would not occur. One would have expected a better solidarity in the organised *service* but when we find two senior members of the provincial service contesting the one seat in the Academic Council our fears are put to rest. Rumour has it that partisan spirit was behind it, but we are not so sure of it. It is nothing but an expression of the dissatisfaction at the way medical affairs in the University are being run by a clique.

The General Practitioner.

By E Kaye Le Fleming, M.B.

Chairman of the Representative Body, British Medical Association.

Some day and somehow the health services of the country must be bound together in such a manner that every citizen of the State can obtain a full medical service in his home, or in an institution, where every resource of medical science will be at his service

The Fourth Andhra Medical Conference,

BEZWADA.

Dear Doctor,

The Fourth Andhra Medical Conference is to be held this year at Bezwada in Easter on the 30th and 31st March 1934 and we cordially invite you to participate actively in its deliberations.

Arrangements are being made for an Exhibition of Medical and Surgical Appliances and Drugs.

Members of the profession are earnestly requested to contribute to the success of the conference by attending as delegates and by sending papers containing original ideas bearing on Modern Medicine and Surgery and on new methods of treatment. Clinical demonstrations are also solicited.

Papers should reach the secretaries before the 10th March 1934. The delegate fee is Rs. 2 which may be sent in advance to the Treasurer, Dr. J. Dakshinamoorty, Bezwada, or paid at the Conference.

We specially request all the Doctors in the Kistna District to enroll themselves as members of the Reception Committee and help to make the Conference a success.

We hope that, through your co-operation, we may be able to advance the cause of Medicine and promote the interests of the profession, by decisions arrived at the Conference.

Yours sincerely,

G. M. SIVASUBRAMANYAM,

D. KAMESWARA RAO,

A. UMAPATHI MUDALIAR,

Secretaries.

at a cost within his individual means. There is evidence enough that such provision can only be secured by any such health machinery must depend on maintaining unimpaired the intimate personal relationship between doctor and patient which is the root principle of medical practice to-day in this country. In other words, it must be built up on a general practitioner basis.

I would plead to-day that the teaching hospitals should pay special attention to the needs of those students who intend to engage in general practice.

Have you ever considered the relation between the student and his teachers in this respect? Three-quarters of the students of a hospital will pass into general practice, and in the whole course of their preparation for this career never once have they been taught or examined by anyone who has had experience in this kind of work. Is it not time that this fact was faced? If the answer is that the existing system is the best, let us at least know the reason why.

I hold that there is no better service that you can render to the public and the State than to turn out a good type of general practitioner, and I would like to see medical education primarily directed to this end. And I venture to ask this question. Could not the altered outlook I have mentioned possibly afford some solution of the curriculum problem? The medical student spends much time over detail which is of no real use to him as a general practitioner, and this time could be spent with advantage on subjects a knowledge of which is essential in general practice and which at present he has to acquire after he has qualified.

It has always seemed to me an anomaly that in an institution like St. George's which in a sense is a factory engaged in large measure in producing the best type of general practitioner, there should be no place on the staff or in the teaching machinery for a general practitioner *as such*. A knowledge of general practice would be of definite advantage to every member of the profession whatever his specialty; but if there is one class more than another to which this applies it is to those who teach and examine our students. The difference between hospital and general practice is wide and important, and I am sure that something could be done to prepare the newly qualified for the difficulties he will have to face in general practice. Somewhere in the out-patient department, especially, there would seem to be room for a general practitioner's special knowledge, not only in a teaching capacity but possibly as an aid to a sifting process which would help to ensure that abuses of the department were checked. Whether such facilities, if available, would appeal to the student, experience alone can determine, for the natural aim of the student is to pass his examination, and he will look upon any case in the light of its value for examination purposes rather than its practical utility in his later career. The line of distinction, however, is not, after all, clear cut, and I am convinced that an experiment on these lines is worth-while.

I would also make a strong appeal for special instruction in National Health Insurance work It seems hard to believe in, and still more to defend, a system which ignores completely, in its teaching capacity, a State contract which every registered medical man is free to join the moment he is qualified, which, as I have stated, has been entered into by 15,000 doctors at the present time. Luckily in this case a few lectures can cover the most important difficulties, such as the regulations governing certification, prescribing, and record keeping. The service offers a quick entry into general practice, and I often think that the service is least under-

stood by those of our own profession who are outside it. *The old idea that the panel service is a step towards a whole-time State medical service is the exact opposite to the truth.* It is, in fact, our greatest safeguard against it. It is a recognition by the State that a general practitioner service with free choice as between doctor and patient is the best system of medical attendance. The service should have the sympathy and goodwill of every member of the profession, for the most obvious reasons. If I am wrong in the view I hold, then I say the profession has been put to the test, and failed, and that a State medical service, with the inevitable cleavage of the profession into factions, is the only possible line along which to expect future development.

At the present moment the State is committed to supply a general practitioner service to some 15,000,000 of the population of England, Scotland, and Wales, and has contracted with nearly 15,000 doctors to that end. The National Health Insurance service, though not without its imperfections, has been and is a success, though it works least satisfactorily in densely populated areas. Like so many institutions in this world (such as married life) you hear all about its failures and little enough of its success. It is not sufficiently recognised that National Health Insurance is a great scheme of *preventine medicine.* The doctor has every inducement to keep his patients well. The general practitioner is growing a little tired of having the words preventive medicine continually put to him as something new that he has never thought about. Preventive medicine means nothing more than the education of the public in the art of keeping well. The general practitioner has been doing this, as he does most of his work, quietly, steadily, and effectively, without making a fuss about it, from time immemorial.

Many of the hospitals of this country are in process of extending their scope in order to supply the needs of people of modest means. Contributory schemes are becoming universal, and special hospitals for this class of patient are increasing rapidly. In such a development it is inconceivable that the general practitioner should have no place. Somewhere and somehow you must avail yourself of his services to do the work he is well capable of doing. There are many difficulties but they are, I think, exaggerated and altogether insignificant in comparison to the principle at stake. Leave him out and you will encourage him to find a substitute for your hospital which will not break the personal tie between patient and doctor, or at least tempt him to avoid using your institution as far as possible. Leave him out and in some areas, I am sure, you will run grave risk of dividing the local profession into two parties, to the detriment of both. Leave him out and you will deprive him of a most important means of keeping himself efficient and improving his value as a doctor.

The profession recognises that the hospitals must have all the material they want for teaching purposes; that every case of emergency or difficulty must continue to have free access to their doors; that nothing must ever be done to damage in the least their wonderful record of response to the needs of the sick. But if they make claim for increased support on the grounds of the steady increase of their out-patient work, and ask for sympathy for an overworked specialist staff, they must satisfy the profession at least that they are not encumbering their machinery with unnecessary work. If they spend money and the time of a specialist staff on work that can be just as well done by outside

general practitioners, and for which provision has already been made by the State, they deserve as little sympathy in that respect as the general practitioner who takes advantage of their charity to escape his own obligations.—*Lancet, October 8, 1932.*

Report on Medical Relief Work.

The following account of medical relief work in the earthquake-stricken areas in Bihar has been issued by the Indian Medical Association.

As soon as the news of the catastropic earthquake was published in the papers, the Indian Medical Association sent Dr. S. C. Mukherjee with emergency medicines to Monghyr, and Drs. A. Bose and A Chakraberty to Muzaffarpur to supply us with information as to the requirements of the situation.

A complete medical unit was immediately mobilised and was ready to start for Monghyr, but was deviated to Muzaffarpur at the request of the Bengal Red Cross authorities who volunteered to take complete medical charge of Monghyr. The Indian Medical Association, however, left one medical officer to help the Civil Surgeon in relief work, which he rendered from the 19th to the 26th January.

A complete medical unit under Dr. S. C. Roy, consisting of three doctors and nineteen medical volunteers, equipped with eleven tents, necessary medicines and appliances started for Muzaffarpur on the 22nd January and established a Base Hospital there. This hospital rendered timely relief to several hundreds of injured and sick persons. The Base Hospital worked in complete collaboration with the Government and the public health machineries and with the Bihar Central Relief Committee. A few days later the Indian Medical Association Base Hospital became the connecting link between the other medical relief organisations in the outlying districts and the central organisation at Patna.

Subsequently, the local medical relief organisations of Muzaffarpur took a very wise step by forming a Joint Medical Relief Board, where the present Medical Officer-in-Charge of the Indian Medical Association Camp at Muzaffarpur is acting as its General Adviser. An idea about the kind of work which is being done by these modest workers will be formed when it is said that between the 2nd to the 7th February they treated 556 cases, of which 333 were surgical, besides 25 indoor patients, who were mostly injury cases and a few suffering from small-pox and other infectious diseases. The Muzaffarpur Indian Medical Association Base Hospital is fully equipped with general wards and isolation camps. Besides distributing medicines to the destitute patients, they are also giving clothes and food to the poor relations of the patients. The Base Camp is also managing a branch hospital at Kalyani, a part of the town which suffered very badly from the earthquake. In connection with the medical relief work at Muzaffarpur, the Indian Medical Association wishes to record with grateful thanks the services of three European ladies of town who are working as nurses at the Base Camp every day.

Another body of 7 doctors and 23 medical students started on the 27th January under Dr. S. K. Guha, for Sitamarhi, which, on arriving at Patna, was split up into two parts, as a Patna Medical College unit had already been despatched to Sitamarhi. One part was despatched to Samastipur to work under Dr. S. K. Das and one part to Madhubani, which was chiefly manned by the Social Service Section of

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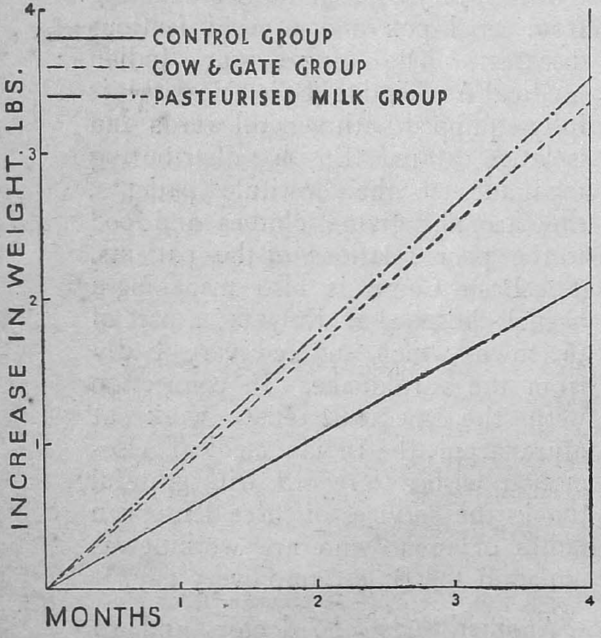

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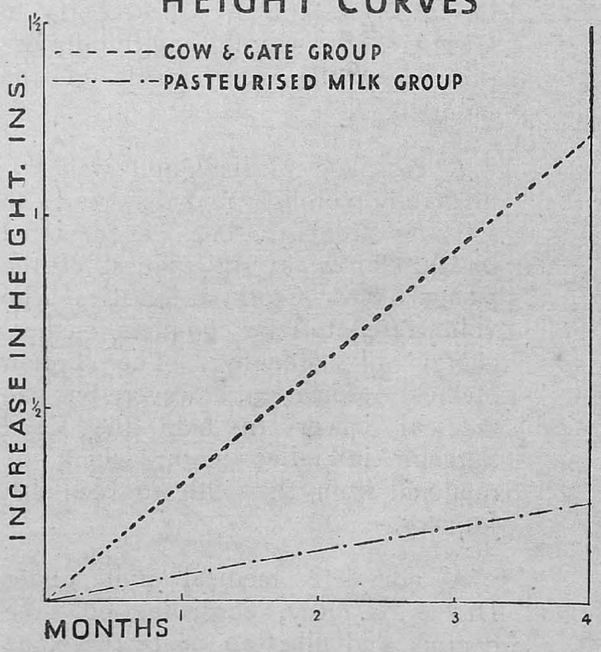

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the Calcutta Medical College. The Samastipur unit was subsequently disbanded, as there was not enough work to be done beyond the capacity of the local hospital. The Madhubani Camp is doing splendid work and, in addition to working locally, has been compelled to open a branch at Jhanjhanpore, 20 miles from Madhubani.

Besides these, the resources of the Indian Medical Association have been utilised for supply of medical men to the Calcutta Salt Concern Society, who are working at Madhupura (Monghyr) and other relief organisations. It appears from the communications which have been received from the local units as well as from the Bihar Central Relief Committee, the Inspector-General of Civil Hospitals and the Director of Public Health, Bihar, that the work of emergent medical relief to sufferers from the earthquake will not last very much longer, but that owing to the approach of the summer, it is apprehended that cholera, dysentery, malaria, small-pox and plague may break out in the affected areas. The Indian Medical Association takes this opportunity to appeal to all medical men with public health qualifications to keep themselves in readiness for selfless volunteer service in those areas, should any occasion arise.

The Indian Medical Association is working in close-co-operation with the Bihar Central Relief Committee, and the Inspector General of Civil Hospitals and the Director of Public Health, Bihar, as also with the District Civil Surgeons and the local medical men. Special mention must be made in this connection of the splendid services which Capt. P. B. Mukherjee, Radiologist of the Patna Medical College Hospital, who acting as the liaison officer between the Government, the Bihar Central Relief Committee, the Base organisations and the Indian Medical Association, has rendered for the medical relief of the earthquake-affected areas. Mention must also be made here of the assistance and co-operation which the Association received from Lt.-Col. J. A. S. Phillips, Director of Public Health and Acting Inspector-General of Civil Hospitals of Bihar, throughout the operations. The Indian Medical Association records its grateful thanks also to all medical men and volunteers who have rendered valuable services in the stricken areas. The Indian Medical Association Camp Hospitals at Muzaffarpur and Madhubani were visited by Pandit Jawaharlal Nehru, who recorded his appreciation of the work done by the Association. It is gratifying to note that his Excellency the Governor of Bihar and Orissa and the Public Health authorities have highly appreciated the work done by the Association. The Association expects to continue the work so long as medical service is required in those areas. Medicines and appliances necessary for two complete units have been kept in reserve at Patna for emergent relief work.

To bring modern science to the aid of the injured, the Association has sent a Radiologist (Dr. K. Chatterjee) with a mobile X-Ray unit to Monghyr and other centres where his services may be required.

The Bihar Central Relief Committee and the medical authorities in Bihar feel the need of the services of lady doctors and nurses for female patients. As lady doctors are not very numerous in India, the Indian Medical Association appeals to all qualified Indian lady doctors and nurses who can afford to volunteer their services for at least a fortnight or three weeks for relief work in the affected areas.

MEDICAL RELIEF IN MUZAFFARPUR.

The medical units are still engaged in their important work of attending to the sick and wounded.

The Indian Medical Association of Calcutta which has been the first to arrive in the field of medical aid, with Dr. S. C. Roy and Dr. Dhar (who arrived later) and other eminent doctors and students have been doing splendid work even in spite of being badly handicapped for want of proper facilities such as X-Ray, etc., since most of the cases they had to attend to were surgical and even then they have covered the largest area. The Muzaffarpur camp of the Indian Medical Association served as the Base Camp (of the I. M. A.) and their subsequent units were distributed in rural areas such as Sitamarhi and Madhubani, etc. At present the I. M. A. camp has a strength of ten doctors and six senior students with Dr. S. C. Roy as General Adviser and Dr. Dhar as officer-in-charge. The total number of cases attended both outdoor and indoor is 2,114, out of which 2,003 are injured, 205 infectious fever, 170 simple fractures, 37 compound fractures, eruptive fever and the rest 492 other medical diseases. The relatives who stay with the patients are also served food by the I. M. A. They have also distributed blankets, bedsheets, shirts, coats, dhoties sarees, etc., to about 700 people.

JOIN THE UNION.

ASSOCIATIONS.

Godavari Medical Association.

The monthly meeting of the Godavari District Medical Association, Cocanada, took place at Samalkota on the 10th February in the Board High School premises.

Dr. B. S. Prasada Rao of Samalkot and other members of the area were "At Home" to the guests numbering 58, in all, from all over the District.

Major T. S. Shastry, I.M.S., presided over the meeting. A number of interesting cases of groin glands, joint swellings and thickened bone were exhibited from Government Headquarter Hospital, Cocanada, and a lively discussion ensued on the diagnosis of the same. Major A. Krishnamurti of Rajahmundry dealt with some features of syphilitic affections as distinguished from tubercular and other affections of bones and glands. Dr. Prasada Rao exhibited a case of "want of growth" in a child of 5 years looking like a child of two years.

Dr. V. C. Kamaraju of Cocanada read out detailed notes of a case of fever, swelling on the right side of abdomen, and discharge of a large amount of pus through the bowel, which eventually proved fatal.

Major Shastry delivered a postgraduate lecture on "Head Injuries."

After dinner and music, the gathering dispersed.

Salem Medical Association.

The second anniversary of the Salem District Medical Association, came off on the 5th February 1934 in the premises of the bungalow of the District Medical Officer at Hastampatti.

The function was presided over by Lt.-Col. N. K. Bal, I.M.S., District Medical Officer, Salem. There was tea at 4 p.m. and then the business

meeting commenced. Office-bearers were then elected.

The minutes of the previous meeting were read and adopted. The Secretary, Dr. K. Ramanathan, L. M. & S., presented the annual report.

Towards the end of the meeting the President spoke congratulating the members on the progress which recorded last year. He exhorted them to take an abiding interest in the association.

Madura Medical Association.

The sixth annual meeting of the above Association was held at the bungalow of the District Medical Officer, Madura, at Tallakulam on 9th February 1934. Col. Sir Frank O'Connor, Kt., I M.S., Surgeon-General with the Government of Madras, was present. Mrs. and Major Verdon, I.M.S., the President, were 'At Home' to the Surgeon-General and the members of the Association.

After a group photo and tea, the members were introduced to the Surgeon General. After a few remarks, from the President the sixth annual report was presented by the Secretary, Dr. A. N. Menon. The Surgeon-General congratulated the Association on the inauguration of the journal and other useful activities. Election of office-bearers was then proceeded with and the function terminated with a vote of thanks.

Vizagapatam I. M. P. Club.

A general body meeting of the Vizagapatam Independent Medical Practitioner's Club was held in February when Dr. M. V. Krishna Rao, B.A.,M.B., B.S., was 'at home' to the members at his dispensary. Dr. P. Rama Rao, L.M.P., was elected President and Dr. M. V. Krishna Rao, Secretary, for the current year. A resolution of condolence on the death of its late President, Dr. C. Mallick, L.R.C.P.S., was adopted.

Trichinopoly District Medical Association.

The fifth inaugural meeting of the Trichinopoly District Medical Association was held on 25th February 1934 in the premises of the South Indian Railway General Hospital at Golden Rock with Dr. C. E. R. Norman, Chief Medical Officer, South Indian Railway and President of the Association, in the chair. About 60 members were present. Dr. A. Vasudevan, M.B.B.S., Assistant Pathologist of the Madras Medical College, delivered an interesting lecture on "Easy methods of test for various diseases." There was a demonstration of cases, two by Dr. Rajan, one by Dr. Sambasivan, and one by Dr. Iravatham, after which the President, in the course of his concluding remarks, expressed his gratification at the keen interest evinced by the members in coming long distances to attend the meeting and at the high level of discussions that prevailed. A dinner was given by Dr. Norman the same night in honour of the guests.

West Godavari Medical Association.

The annual general body meeting of the West Godavari District Medical Association was held on 24th February 1934 in the Municipal office with Mr. C. Ramanujayya, District Medical Officer, in the chair. Members of the Association from different parts of the district attended. The annual report was read and approved. The meeting resolved to admit the L. I. M. practitioners to membership of the Association. The election of office-bearers then took place. The District Medical Officer was elected President and Doctors H. V. Jogayya Sarma and M. Jagannadharaju were elected joint secretaries.

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BULLETIN
OF THE
SOUTH INDIAN MEDICAL ASSOCIATION

MARCH 1934.

Bradycardia.*

Dr. T. Krishna Menon, M.B.C.M., L.R.C.P., M.R.C.S.

Physician, General Hospital, Lecturer in Cardiology, Medical College and Medical School, Madras.

By Bradycardia one means a lower heart rate. The word slow pulse is misleading as the pulse might be slow in frequency or in the propulsive force. The average rate of the heart in a healthy individual is about 70 per minute. Athletes indulging in severe and prolonged exertion often show a resting heart rate about 60. For all practical purposes a resting heart rate under 50 may be considered pathological. Bradycardia may be functional in origin. It is present in jaundice, with a high arterial pressure, in exhaustion after convalescence, as a result of intrinsic poisons like tobacco; as a reflex from pain, from cerebral causes like hæmorrhage, in psychic conditions especially when associated with vomiting, in anæmia and after prolonged administration of digitalis bradycardia is found. This bradycardia may be due to vagal stimulation. Gaskell in 1882 experimentally slowed the heart by vagal stimulation. It may also be due to the direct action of the toxin on the heart muscle. These cases are supracardiac in origin and I propose here to deal with only those cases which have a cardiac origin.

The most common cause of bradycardia is *Auricular Flutter.* Flutter is caused by the *circus* movement where the impulse follows a circular path having its orbit around the mouth of the vena cavæ. The path is constant as contrasted with fibrillation and the refractory period is longer than in fibrillation. It occurs in all ages, the lowest reported age being 5 years. Usually it occurs in later life between 40 and 70 and is then associated with myocardial scarring or senile arteriosclerosis. Diptheria, rheumatism, syphilis, chronic mitral disease might present auricular flutter in their course. Palpitation and sometimes fainting may be present. The ventricle not being able to respond to the very frequent individual auricular stimulus in flutter (and it is anything from 250-400 per minute) a physiological block results. This is due to the refractory period of the auriculo-ventricular node being longer than that of the auricle.

Diagnosis of flutter can be confirmed only by the electro-cardiograph. Here regular f waves will be seen in place of the usual P waves. The Q. R. S. complex is not affected. In flutter the rate may be temporarily slowed down by pressure on the carotid sinus. The heart rate remains constant in all positions. Exercise might double the number of beats in case of 2 to 1 block or if the block is irregular might regularise the beat or give a less frequent irregularity.

Treatment of flutter is by digitalis or quinidine. If quinidine is used, a preliminary dose of 3 to 5 grs. of quinidine sulphate is given. Tachycardia or other toxic symptoms of cinchonism are watched for and if not present, quinidine sulphate is given for 1 or 2 days at doses of 5 grs. at 2 to 4 hourly intervals, subject to a maximum of 5 such doses in 24 hours. It may also be given by what is known as the slow method. Here quinidine is given in doses of 5, 10 and 15 grs. on successive days. The danger of giving quinidine is the 1-1 response that might result. In flutter the rate is anything between 200 and 400

* University extension Board lectures.

and if the ventricle responds 1-1 the ventricular beats necessary amount to the same number. Defective ventricular filling and rapid exhaustion of the myocardium result in cardiac failure and death. If there is heart failure or in the presence of acute infection quinidine is a dangerous drug. Then digitalis is the stand-by. It may be given in daily dram doses of the Tincture. The pulse is to be watched; if a marked irregularity presents itself, the drug is stopped. This irregularity is due to the onset of fibrillation and if the drug is now stopped, the normal rythm returns. Strophanthus may be given intravenously with good results.

The other cause of a slow pulse is *Heart Block*. This block may be situated in any part of the conduction system. Sino-auricular block is not common and can be diagnosed only by the electro-cardiograph. Usually it is associated with pronounced sinus arrythmia and excepting in cases where it is due to disease, it is usually vagal in origin. The usual site of block is in the auriculo-ventricle node or the bundle of His. The heart block may be complete or incomplete. It may slow itself in a simple prolongation of the P-R. interval. In incomplete block, certain auricular impulses do not pass to the ventricle and thus depending on the number of ventricular response, we have 2-1, 3-1 etc., block, or if the impulse transmission is irregular, an irregular slow pulse is found.

Disturbances of conduction with a prolonged asytole cause an increased intraventricular tension. In complete heart block, better filling of the ventricle and better output into the system is present. In incomplete heart block, if irregular, there is waste of energy and lack of power in the ventricular action. If the asytole is prolonged stasis in internal organs with dizziness, unconsciousness or even convulsions result. This is present mostly at the change-over from the incomplete into the complete block and gives rise to what is known as the Stokes-Adams Syndrome. Stokes-Adams Syndrome shows itself in a sudden slowing of the pulse rate and cessation of cardiac action associated with loss of consciousness or convulsions depending on the period of asytole. It is present more in women than in men. The age of onset varies with the cause. In young people it is the result of acute infectious disease; in the 2nd to 4th decade syphilis is the cause; while in the old, arterosclerosis of the senile variety and the degeneration resulting therefrom becomes the causative factor. The cerebral symptoms are due to circulatory disturbances. Morgagni quotes a classical example. "I will just skim over those many things which I have observed for a long time in my fellow citizen, Anastasio Poggi, a grave and worthy priest. He was in his sixty eight year, of a habit moderately fat or of a florid complexion when he was seized with *epilepsy which left behind it a great slowness of pulse* and in a like manner a coldness of the body. But this coldness of the body was overcome with 7 hours, nor did it return any more, though the disorder often returned but the slowness of the pulse remained."

The mental functions are suspended with asytole of 3 to 7 seconds, cyanosis, stertorous breathing, twitching of the face and upper limbs in 15 seconds and unconsciousness from 8 to 20 seconds. The twitching of the limbs may be local or generalised and if the attack is over, the patient is in no way worse than before. On auscultation the ventricle is silent. Rapid undulation in the viens of the neck may be seen. The treatment depends on the cause. Anti-syphilitic measures are used if it is of syphilitic origin. In non-syphilitics Pot. Iodide only

aggravates the condition. On the basis of an increased pulse rate in Thyrotoxicosis, Thyroid extract has been tried and with good results. Digitalis is contra-idicated. If the block is due to digitalis toxaemia, it is removed by atropine. Diuretin with its consequent coronary dilatation improves the myocardial circulation. Intracardiac injections of adrenalin have been reported to be beneficial. Barium Chloride is the remedy for Stokes-Adam Syndrome. Parsons Smith has reported very good results with it. ½ gr. twice a day is given. The contractions become stronger and prolonged, the blood pressure is raised and the heart rate is accelerated. It acts directly on the cardiac muscle. In complete heart block the ventricle takes up its own idiopathic rythm which is usually 30 to 40. No treatment is necessary in these cases. It is not incompatable with life or active physical exertion.

The Reform of Medical Education.

By Dr. J. Tandler,

Professor at the Medical Faculty of Vienna University and the Chief of the Social Welfare Department.

Complaints regarding the inadequacy of medical education and proposals for reform in this sphere were already heard before the war and have since become much more clamant.

In every civilised country, attempts have been made, by means of resolutions and of investigations carried out by professors or the authorities, or even by the students themselves, to formulate principles the application of which was calculated in the opinion of their supporters to remedy the various defects, whether recognised or not.

The general opinion has always been that university instruction called most urgently for reform, and the changes in the medical curriculam would bring relief. Thus, new regulations for studies and examinations have been issued from to time, after long and wearisome discussion, but no appreciable progress has been achieved.

There can be no doubt that the present position as regards the training of medical practitioners has its share of responsibility in explaining the low material, moral and social level to which the profession has fallen, but it would be unfair to attribute the whole blame to their training.

The medical profession cannot be dissociated from its social and political environment, nor can doctors be isolated from other workers.

The reform of medical education cannot therefore be regarded from the strictly limited standpoint of university teaching; the whole question must first be analysed before we can decide what is to be done in the narrower field of medical education.

We must first of all be quite clear on the point—no single formula applicable to all countries can be found. Each nation lives its own life, has its own art, its own culture and, like the individuals, makes its contribution to that common stock, and is in some sort influenced by it. We must none the less endeavour to set out principles of general application.

A first category of questions concerns the doctor's *conditions of life and means of livelihood* under present economic conditions, the second concerns *his professional education* in relation to the university in general and the medical faculty in particular, and the third *his training for university teaching*.

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only. He deals in the health of those who entrust their health to his care, this anomalous position being mainly due to economic causes.

The doctor is interested in the health of his patients and does, in fact, spend himself in their interests; but it is not by health that lives but—just the contrary—by sickness. The number of his visits and prescriptions is not determined exclusively by the condition of the patient, but sometimes also by his own pecuniary interests. This struggle of conscience which he has to face day in and day out does not strengthen the moral consciousness, but tends rather to sap it. Consciously or unconsciously, a doctor comes to regard himself as nothing more or less than a wage-earner, and is no longer satisfied with the sure but modest income of those who administer the common property of mankind, though really a trustee of human health. He refuses to be placed on the same footing as the priest, the judge or the teacher.

This attitude of mind explains many of the criticisms directed against the medical profession. There is such a thing as the right to health, just as there is the duty to be healthy, both for the individual and for society. The right of the community to require health in the individual is legally acknowledged wherever there are laws dealing with epidemics, as it is the primordial right of the community to guard against infection through individuals, and the segregation of lepers thousands of years ago was simply an expression of that right. Human society, which requires the individual to be healthy, also gives him the right to demand that his health be protected by it. Had this argument—based on the normal relationship between the individual and society—ever been followed to its logical conclusion and acted upon, the medical question would have been solved long ago.

It would never occur to anyone to think that a judge should in each particular case exact payment from an individual appealing to the courts. Justice, as a common good, is guaranteed by the independence of the judge, who is paid by society for his work and need not therefore take into consideration the pecuniary circumstances of the plaintiff. Elementary education is an uncontested right in all civilised communities, and no teacher at a Government school is paid for his work by his pupils. Priests, who are appointed by a religious body or by the State—that is to say, ultimately by society—are not paid by individuals, but act as the mandatories of society.

Similarly, a doctor should be the mandatory of society and be paid by it, so that he may administer health, as a judge administers the law. Deliberate compromise for economic reasons, on the pretext of belonging to a liberal profession, is what has given the medical profession its commercial character, and this conflict of interests it is that has led to the present material and moral plight of the medical profession.

Nevertheless, there are attempts at improvement here and there. The health offices set up for the use of the community are a beginning. The doctors employed in them no longer treat private patients, but serve the community. In progressive countries and cities, where the value of these health offices is realised to the full, the doctors attached to them are forbidden to engage in private practice and are paid like judges or teachers. The extension of medicine beyond the bounds of therapy to prophylaxis and preventive care has led to the creation of a new category of doctors—social welfare doctors. They, too, have been obliged to give up their private practice and receive a fixed salary for their work—at least, in those countries

in which the importance of this category of doctors is duly appreciated. Here it is no longer a question of the observance and application of health regulations; men and women need not be ill before they can benefit from the doctor's scare.

A further step has been taken in appointing health insurance doctors. We do not, of course, intend to go into the whole problem of health insurance here but there is one point to which reference must be made. Health insurance doctors no longer receive private fees, but treat the patients allocated to them within a certain area for a fixed salary. The weaknesses of the system may be attributed here, again, to the fact that it is in the nature of a compromise, since, at present most of these doctors still have private practices, though there are notable exceptions. When the health insurance offices decide to the reserve the services of their doctors exclusively for their members and forbid them to have private practices, this important category of doctors will cease to be business men and will assume the more dignified position of administrators independent of private fees.

A great many arguments have, of course, been advanced against such a system, especially by the doctors themselves. They consider that they have suffered injury, since their whole education has inculcated in them the idea that their profession is a means of making money. Much is said about bureaucratisation, with all its attendant evils. Teachers, judges and ministers of religion are not necessarily bureaucratised, for bureaucratisation, in the sense in which we understand the word, is not the effect of a system, but an expression of individual personality. There are bureaucrats in the liberal professions, just as there are independent men in official positions.

All medical intervention is individual action, but it should not be the subject of personal remuneration. Doctors must learn to look beyond private fees and aspire to the higher ideal of retribution for service to the community. They will have to adapt themselves to the rights of society and be more punctilious in carrying out their duties towards it. This is the social foundations on which the medical edifice of the future will have to be constructed. True, for this, doctors will need a training radically different from that which they mostly receive to-day, and this brings us to the question of the university education of doctors.

***

Universities presuppose secondary schools, where the pupils are prepared, so that much of the university question is really a question of secondary education. We do not intend here to go into the controversy of the last few years on secondary schools. One may be in favour of the classical or of the modern side in education, but one thing is certain—secondary schools are not merely intended to raise the educational level of our young people, but are, and must remain, a preparation for the university. As a medical professor of thirty-five years' standing, through whose hands many students coming from secondary schools have passed, I may be allowed to express a frank opinion. Instruction in the secondary schools (I can, of course, only speak for the old Austria and the Republic of Austria) has, during the last decade become easier, but not better. Its selective value has greatly diminished. Adaptation to the times in which we live—so essential for everyone, and especially for the man of science (and every doctor must be that to some extent) is often inadequate, if not entirely absent. Our secondary schools especially those of a classical tendency —are still too deeply imbued with ideals borrowed from the Greek and

Latin cultures; contemplation of the past deprives our young people of a just appreciation of the present. The desire of so many university professors to select their own students—to inaugurate a sort of entrance examination—is perfectly comprehensible, though I personally doubt if the increase in the number of examinations, however necessary, will lead to really satisfactory results. University reform therefore implies secondary school reform which, for various reasons, must no longer be delayed.

***

The reform of medical teaching and medical training generally depends on the attitude adopted towards the universities and their faculties. We need not discuss here the out-of-date system so often found in our universities, nor need we consider whether they can continue to exist in their present form. The question is rather: What are the faculties actually doing to train students for their future careers?

Two alternative have long been in conflict with one another. A faculty is either a professional school, or it is part of the university, and, as such must fulfil the requirements of a university. A professional school is there to impart the existing store of knowledge in the most adequate fashion and in the shortest possible time to those whose future profession requires special technical knowledge. The scientific horizon must not, of course, be too restricted, but pure research is not necessarily an integral part of the curriculum of the school. The position is quite different in the university, though the latter has long ceased to be a *Universitas literarum.*

Research work is a vital necesisty in any university. The university professor must be essentially a research worker, possessed of a critical sense resulting from the perfect mastery of the subject born of his own researches, and a pedagogue capable of imparting his learning to others. On the foundation of knowledge already acquired must be constructed the spiritual edifice of research work. This essential duality of function explains the inadequacy in one direction or another and, to a large extent, the conflict which every university professor and, indeed every university has to face. Professional schools alone are not enough: nor are the faculties as we know them to-day. The defects of faculty instruction cannot be remedied by an increase in the number of subjects or examinations, but only by a change of system. This change must apply both to the subject-matter and to the form in which the instruction is given. Both these points have often been discussed.

As regards the form, some are partisans of the old form of academic instruction given in a lecture-hall by a professor, as constituting the only adequate method of instruction, while others maintain that the substitution for oral instruction of seminars and laboratory and hospital work will solve the problem of medical education. Many illustrations and arguments can be produced in support of either view.

In this connection, too much importance is perhaps attached to method and too little to the personality of the teacher; here, as in other walks of life, it is personality that chiefly counts. The academic professor is not a walking text book and it is not his business to reproduce all his knowledge for the benefit of his students, but rather to stimulate the latter, by the style of his lectures and his method of propounding problems, to think for themselves. The fact that not all academic professors are capable of doing this is the fault, not of the system, but of the choice of professor.

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of the whole field of learning must not disappear. That is how the professor communicates the results of his own experience and inculcates in his pupils a taste for research. This kind of teaching must not be neglected in future if medical instruction is not to degenerate into medical " drill." For this reason, the entire replacement of other forms of instruction by seminar and practical work would certainly be an extreme and exaggerated measure There is the danger of instruction degenerating into casuistical discussions, of the lack of a comprehensive or synthetic view of the subject. Already, in many clinics, the systematic course of pathology has been abandoned; the students are given innmerable object-lessons without being allowed to gain an insight into the disease themselves or to become acquainted with the psychology of the sick, who, after all, cannot be ignored.

This does not mean to say that clinical teaching in the seminar or laboratory and practical work are superduous. Medicine must be, not *learnt* but *lived* by the students, and, for this, hospital and laboratory work are indispensable. The student must not only receive impressions through sight, hearing and touch, but must live in the atmosphere surrounding every sick-bed, must learn to sympathise with human suffering before he can hope to succour it, and no professor in the world will ever be able to teach all this.

What is wanted is a large staff of assistants who, under the influence of their master, have themselves become teachers, and for this they must have time, and must be forbidden to have a private practice. When instruction and business conflict, business always wins. There are faculties where the assistants have flourishing private practices of their own and, in consequence, devote too little time and attention to their essential duties namely, instruction.

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A much more difficult question is *what* should be taught, and this is, moreover, a question that cannot be solved by mere curricula or regulations. What must be realised is that doctors cannot and should not know all that their professors regard as indispensable. We have to admit that professors are often tempted to overestimate the importance of their own particular subjects and teach them as if every student was to become a specialist in that branch. Here, also, the master is known by his capacity to confine himself to what is indespensable. Many professors will never be cured of their partiality towards their own subjects. Perhaps the best method would be to reduce to a minimum the hours of instruction in the several branches. Both professors and students would still be free to give or attend as many optional lectures as they desire. The rationalisation of compulsory lectures must therefore be one of the first reforms.

It is, however, not only the amount of instruction in the various compulsory branches that must be limited, the *number* of subjects should also be restricted. Compulsory subjects there must be, and their limitation is rendered the more difficult by the present tendency to make as many subjects as possible compulsory. Medicines has been badly hit by the modern mania for specialisation; specialised research work has made great progress and is, indeed, a condition of success. Specialisation in instruction has, however, done harm to the medical profession. This tendency is still increasing, and the number of branches which, according to their professors, students ought to study seems never-ending.

It is time that medicine was regarded from the point of view of the require-

ments of patients and not from that of existing and future Chairs. We must have the courage to jettison superfluous medical knowledge which seldom if ever proves useful in practice. I myself, as a professor of anatomy, am convinced that many Chairs of anatomy suffer from an excess of anatomical instruction. Description of the smallest apophyses of the skeleton and the enumeration and description of the smallest muscles of the back and the finest arterial branches may be very interesting, but what good is it to doctors? After every examination—and, unfortunately, these details still form the subject of examinations all this is dropped and forgotten to make room for fresh knowledge in the shape of minute histological details.

In the preface to my textbook, I said advisedly that students learn too much and know too little, and what I have said—in the light of my experience of anatomy, which can only be taught with a view to practical application, may be said of most subjects. Everything taught must be in the interests of science and research, without being allowed degenerate into professional instruction or "drill." The solution lies not in reducing the amount of theoretical instruction, as advocates of "practical" instruction would claim, but rather in a different kind of theoretical instruction.

True, there is no branch of medicine in which a doctor cannot, upon occasion, act as a saviour. The only question is whether the amount of energy expended is not disproportionate to its practical value. Anyone who saves a fellow-being's eye-sight has done something worth doing, and any oculist has the right to be proud of it. Every doctor should therefore be taught ophthalmology, but is it necessary that every doctor should be an oculist? Ophthalmology is a branch in itself and forms the subject of a special examination, but what does even the best doctor know of it after a few years, unless he has specialised? In my opinion, it is sufficient if a doctor is capable of diagnosing in time conjunctivitis, lesion or abscess of the cornea, trachoma and glaucoma, so as to be able to protect his patients from the worst consequences of these affections. I do not think that one medical practitioner in a thousand would ever undertake an operation for glaucoma, though thousands have probably learned all the details of this operation only to forget them afterwards.

Quite as dangerous as many affections of the eye is *otitis media*. Students have to pass examinations in every detail of ophthalmology, but the same does not apply to diseases of the ear. These inconsistencies will be further multiplied in future. Each new method of medical diagnosis and treatment passes through the stages of research, doctrine, teaching and practice. First a lectureship is created, then an extraordinary Chair, and finally an ordinary Chair. So far, so good.

What we cannot approve is the consequent examination, in which the student is required to prove his knowledge of all these branches. For what is important is not the quantity of his knowledge, but the quality and the fact that he should select what is indispensable to any doctor, since no medical student can know everything, however many examinations he is required to pass. The psychotechnical institutes of the faculties of philosophy say that the human brain is only capable of absorbing new impressions for a very limited number of hours a day whereas the medical faculty, by overtaxing the students' brains, assumes just the reverse of this attitude. The subject-matter, therefore, and the number of branches must be restricted.

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Then, again, a student should not study medicine only, but should, also have an opportunity during this period of his life of developing generally, of going in for sport and participating in the intellectual life of his time. The restriction of the intellectual horizon involved by concentrating on one particular branch of knowledge for years at a stretch is for more likely to make a doctor a bureaucrat than any of those rules and regulations to which doctors object on the ground that they lead to bureaucratisation.

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I would like to say a few words about examination. The whole conception is wrong and is the direct outcome of the kind of instruction given. It is not likely that the professor will expatiate for the years on the smallest details and then magnanimously regrain from demanding a knowledge of them at the examination. There are far too many examinations and far too many subjects for examination. Here, again, some restriction is called for. The application of the various reforms which have here been outlined rather than described is a first necessary condition for any thoroughgoing re-organisation. The training of a doctor must consist of two stages. In the first, he should be taught all things needful for his profession, both theoretical and practical. In the second stage, however, he must learn to be a doctor, and that he can only do by working on his own, under the direction and supervision of those who have already become proficient, persevering until he has mastered his profession. In other professions, this idea is by no means new. In early every country, a future lawyer, after having finished his law studies, must practise for some years as licentiate on probation, while a future judge must, after his studies, spend years in a court learning his duties. It is only in medicine that a student is considered to have terminated his studies and to be in a position to exercise his profession, directly he has passed the study period proper. His is left to decide for himself whether he is to embark on the treatment of patients. Such an attitude I would describe as sheer contempt for health, a gross lack of respect for our fellow-beings.

In some countries, the enormity of this offence has been realised, and it has been decided to introduce a so-called practical year, as if one could, in one year, learn to practise an art which has required six years of preparation. It may well be that the fine reputation enjoyed by Austrian doctors is partly due to the fact that, after they have taken their doctor's degree, they are required, practically without exception, to serve for four years in hospitals as assistants and are already doctors of proved capacity before they go into practice.

However, not all men are equally conscientious; what one does, another will leave undone, and on this depends the life and health of innumerable people. A three to four years' hospital period should therefore be compulsory. No one should be able to obtain the *venia practicindi* unless he can prove that he has really employed these years in acquiring a training, and this would mark the inception of quite a new system of medical education. I am convinced that four to four and a-half years of theoretical and practical training on the lines I suggest would be sufficient. After the examinations, there would be at least a three-year course of practical training in the hospitals, and it would only be at the end of this period that a doctor would be authorised to practise.

I will not go into details. The essential thing is to distinguish, in the education of the future doctor, between theoretical instruction in medicine and training with a view to his future

profession. There must be no compromise here, and it is that tendency to compromise so characteristic of our time, the renders such a refrom difficult, not to say improbable.

All the reforms suggested up to the present will, however, prove inadequate, unless—without prejudice to the therapeutic claims of the individual—the need is realised of familiarising the doctor with the social structure of the society in which he lives, and unless he is acquainted with the legal bases of social policy as a whole and has learned to adapt himself to them. A doctor who has been taught and trained on these lines, no longer haunted by the thought of his daily fees, will cease to be a mere wage-earner, and, as a trustee of human health, instead of following a trade, will take his place in a profession capable of bringing him satisfaction and enhancing his self-respect.—*Medical College Magazine.*

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Modern Weekly, Madras.